

THE RHODE ISLAND MEDICAL JOURNAL



Volume XXIV

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RHODE ISLAND MEDICAL SOCIETY

Annual Meeting, Newport, R. I., May 28-29, 1941

AMERICAN MEDICAL ASSOCIATION

Annual Meeting, Cleveland, Ohio, June 2-6, 1941



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PROVIDENCE MEDICAL ASSOCIATION

ADDRESS OF THE PRESIDENT

JOHN G. WALSH, M.D.
221 THAYER STREET, PROVIDENCE

We gather here tonight for the 94th Annual meeting, and as provided in the Constitution of our Association, through the foresight, perhaps, of some predecessor of fifty years ago, it becomes my duty to provide the annual address, summarizing the accomplishments of the year. As I relinquish the office of President of the Providence Medical Association which I have held for the past year, again I want to thank its members for the honor they have conferred on me. It has been a great privilege to serve and to have had the fine cooperation of the other officers of the Association and of the Executive Committee without whose aid the task would have been impossible.

Had I been faced one year ago with the task of predicting the many services which this Association would render to its members during the past twelve months I daresay I would have failed. Likewise were I now to attempt a forecast of what the coming year will bring, or were I to advance any plan or project worthy of study, I should do so with serious doubts as to my ability as a seer.

This Association has continued its sturdy growth as the report of the Secretary has revealed until it has become one of the largest district societies in the country. An organization this size must continue to exert an increasingly powerful influence in medical and civic affairs of the community.

More and more we are assuming our proper place, assisting in the solution of the problems of our city, especially as they relate to medical and health matters. Four years ago this Association, through the keen foresight of its members, recognized the necessity for more active participation in all matters pertaining to the development and control of medical practice including the various health agencies clinics, industrial medicine and medical legislation, and they realized that we, as a Society, should exercise greater influence in the attempts being made to solve present day medico-economic

problems. To carry forward such a program the Executive Committee, which is responsible for initiating much of the business of the Association, was augmented to ten members-at-large together with the Elected officers, and an executive secretary was appointed and established in a central office in the Medical Library. The wisdom of such a plan and the success it has attained is well-known to most of you.

Members of this Association have become active in the Council of Social Agencies, the Red Cross, the Community Fund, The Rhode Island Tuberculosis Association, The Providence Tuberculosis League, the Blue Cross, and the Providence District Nursing Association, and are assisting at the present time in the Preparedness campaign in cooperation with the State Committee for Medical Preparedness. Our influence has been further extended through the distribution of much educational data pertaining to medicine. Through the office of the Executive Secretary reprints of "The Case of Private Medicine," originally appearing in the "Nation's Business" and generally acclaimed as the best presentation of Medicine's present time status, have been distributed to schools, colleges and libraries throughout the State; as have been copies of booklets of "What It Means To Be A Doctor." Likewise schedules of Radio programs of the American Medical Association have been made available to the same institutions. During the past year thirty-four members have participated in Radio Broadcasts, giving addresses on medical topics which always are of tremendous interest to the laity. Articles concerning the activities of the Providence Medical Association and on the "Pre-School Roundup" have been edited from our executive office and published in local newspapers.

Delivered at the annual meeting of the Providence Medical Association, January 6, 1941.

This year we have undertaken the printing of "Medical News" as the official publication of this Association. This paper, published monthly, contains, besides notices of meetings, matters pertaining to our Association which are considered of interest and concern to all our members. Its success seems to have been assured from the general approval expressed by a large number of our members and from commendatory letters received from many state and district societies in other parts of the country. The executive office has distributed a Federal Income Tax guide with authoritative information that alone saved many members far more than the amount of their dues. Complete reports of all committee activities for the year have also been forwarded to each member of this Association. To the executive office as the pivotal point of the Society came daily many requests for all kinds of information concerning organized medicine.

Perhaps our greatest influence as a group has been exerted in having the long-sought-for Basic Science Law enacted and passed by the State Legislature. Its passage is a tribute to the untiring efforts of the Legislative Committee and we are indebted to those men who gave so liberally of their time to appear before Committees of the General Assembly to interpret and explain the need for such legislation. This Committee also helped to defeat many unsound measures which found their way into the legislative files.

This year has also seen the establishment, through the Committee on Credit and Collection of a reliable service for the collection of overdue accounts.

The Committee on Accident and Health Insurance, following a year of study, has published a Policy Digest, copyrighted in the name of this Association, which has been characterized throughout the Country as one of the "most original and helpful aids offered the Profession this year."

The Committee on Tuberculosis is engaged on a long range program for the control of this disease in our community. Although we have made no direct study of the cancer problem, full assistance has been given the Cancer Committee of the State Medical Society. Within the year there has been inaugurated a new plan for pre-school examination whereby the necessary physical checkup will be made by the man in general practice.

These are but a few of the many activities which could be mentioned, the supervision of which has kept the Executive Committee and the Executive secretary busy at many long meetings. Although the amount of work handled is considerable and often complicated, the Executive Committee always welcomes suggestions and advice from anyone who cares to appear before it, thus aiding in determining general policies that will be of benefit to all. The Executive secretary correlates the work of the many Committee activities, and as our agent at meetings of health and social agencies, civic and business group meetings and before governmental and legislative bodies gives these diverse agencies a clearer understanding of the aims of organized medicine, and we in turn have been able to exert more influence in helping to solve the medico-social problems of our community.

I think I bespeak the sentiment of the other officers and the Executive Committee when I say that what has been done would have been much more difficult except for the work of our very efficient Executive Secretary, Mr. John E. Farrell.

The rapid and almost revolutionary changes that have taken place in American life in the past few years following the profound economic depression of the early Thirties, have seriously threatened the professional and economic welfare of those engaged in the practice of medicine. From many sources all sorts of reforms have been proposed. The older members of this association can look back and realize the progressive changes that have taken place in medical practice as scientific knowledge has increased. But these changes have been made in such a way that the relationship between the private physician and the patient has been strengthened rather than disrupted. Although the National Health Act introduced into Congress in 1939 has been shelved for the time being there is no reason to believe that it or some similar bill may not soon reappear to plague us. It is in measures such as this, that the doctor-patient relationship is being seriously threatened.

Lay interest in medical reform is tremendous. In a recent issue of the JOURNAL of the American Medical Association, under "Current Comment" it was revealed that "a total of 715 courses covering one or more topics in Social Medicine were offered by 139 colleges and universities," but that little

use had been made in any of these courses of material available in the Bureau of Medical Economics of the American Medical Association. No discussion of the broader questions of medical services seems to have been made in these lectures and one cannot help from thinking that propaganda from private, foundational, and perhaps governmental sources may be the font of origin for these educational programs.

Much of this propaganda arising from private sources appears to come from a new type of scientist, the so-called "Social Biologist." These thinkers appear to have had a profound influence on our legislators in Washington, many of whom are advancing reforms in medical practice that will jeopardize our economic security.

It is fortunate for us as a Society, that we have at the present time on our Executive Committee,

men who are thoroughly alert to the dangers that confront us. With our affairs in such able hands we cannot fail to protect our rights so that we may continue to render our community a service of inestimable value.

DANGER FROM SULFATHIAZOLE

NOTICE — Because several deaths have resulted from taking contaminated sulfathiazole, any physician who has encountered a case history of prolonged coma after the patient has taken sulfathiazole tablets is requested to report the case to the Federal Security Agency, Food and Drug Administration, A. E. Ledder, Inspector, 1128 Industrial Trust Building, Providence. Symptoms indicating phenobarbital dosage are of special interest.

COARCTATION OF THE AORTA ASSOCIATED WITH PREGNANCY

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The prognosis in coarctation of the aorta, with or without pregnancy, is difficult to determine. Although it is possible to ascertain the amount of collateral circulation in coarctation of the aorta, it is difficult to estimate the weaknesses in the vascular system that are inherent in this condition. If the prognosis in coarctation of the aorta associated with pregnancy is approached from a statistical point of view, it is found that too few cases have been reported to allow us to come to a definite conclusion. Moreover more than half the reported cases do not give the age at death.

Mendelson¹ found 26 cases of coarctation and pregnancy in the literature and added 3 more cases. In only 11 of these 29 were the ages of death obtained. (The ages of death were 45, 25, 28, 25, 31, 57, 56, 37, 38, 30, 47.) He found that 5 of the 29 cases died in pregnancy or shortly after and that 10 were made worse by pregnancy. He con-

cluded that pregnancy had a deleterious effect in over one-half the cases.

Forty-eight of Abbott's² 200 autopsied cases of coarctation of the aorta were women, indicating a predominance in the male sex. Of these cases, 72.9% of the women and 73.5% of the men died before their 41st year. The fact that a slightly larger percentage of men died between the ages of 20 and 40 might be explained by the more strenuous and hazardous life that men lead, although pregnancy is an added hazard to women.

Hamilton and Abbott³ emphasized the fact that in the majority of cases of coarctation of the adult type, symptoms remain latent until intercurrent infection or excessive muscular exertion cause circulatory failure.

Lewis⁴ noted that heart failure itself in coarctation is associated with infection or changes in the muscle found in advancing years, rather than with increased work alone.

Blackford's⁵ analysis showed that 32% died of spontaneous rupture of the aorta or of cerebral hemorrhage while 70% of all cases died of cardiovascular disease. It is this inestimable weakness of the cardiovascular system in each case which makes prognosis so difficult to determine clinically in coarctation of the aorta with or without pregnancy.

Case Report

This 17-year-old girl was first seen at the Providence Lying-In Hospital on July 5, 1939, having been referred to the cardiac clinic because of unusual heart murmurs. She was born on August 22, 1921, had a normal delivery on September 16, 1939, and died on March 25, 1940, six months and nine days after delivery, at the age of 18 years and 7 months.

The patient had her last period on December 18, 1938. During the first three months of pregnancy, she had some nausea and vomiting, occasional headaches, and some difficulty in sleeping. She reluctantly admitted having had some shortness of breath on exertion and the need of two pillows in order to be comfortable in bed. At times she had slight swelling of her ankles. When she was referred to the clinic she felt well and had no cardio-respiratory symptoms. Her most significant statement was that when she became tired, it was from the waist down.

She had never been informed that any heart trouble was noted either at the time of her birth or later. She had her tonsils removed at the age of 10, had measles at the age of 12, and an abscess in her right ear without complications at the age of 13. Her past history was otherwise negative. She denied having had rheumatic fever or chorea by symptom or name. Her periods had been regular, occurring every 3 weeks and lasting 3 days with a moderate flow.

She left high school during her senior year at the age of 16 and went to work in a mill for two months. She was married at the age of 17 and became pregnant one and a half months later.

Her family history was negative. She had seven brothers and three sisters living and well.

She was a well developed and well nourished girl, 5 feet, 4 inches in height. At the beginning of her pregnancy she weighed 116 pounds and at the time of delivery 136½ pounds.

The extra-ocular movements were normal. The discs were well outlined with deep physiological

cupping, more marked on the left side. The arteries and veins were somewhat narrow, with moderate general pallor of the fundi, and no hemorrhage or exudate. The foveal reflexes were present.

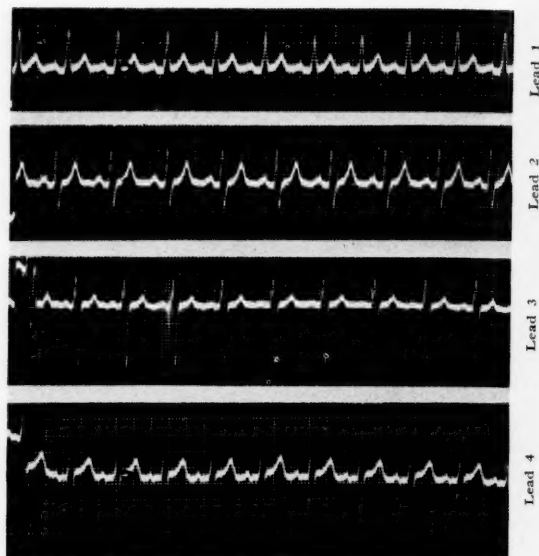


FIGURE 1. Electrocardiogram made twenty-four days before delivery. Note increase in amplitude of QRS deflections and high, pointed T waves.

In all positions there were marked expansile pulsations of the neck vessels. There was no enlargement of the thyroid. She was perfectly comfortable lying flat. On putting one's hands on the shoulders, marked pulsations were noted. There were also marked pulsations in the upper part of the interscapular region, along the course of the dorsal scapular vessels, in the superficial vessels in the intrascapular region, along the course of the lower intercostal vessels, and just below the costal margin along the course of the superior epigastric vessels. There was a loud bruit over these same vessels. The femoral artery was palpable, but somewhat smaller than usual. Pulsations in the dorsalis pedis arteries could just be made out.

The heart was enlarged to percussion to the left anterior axillary line. P_2 was accentuated and slapping in character. There was a loud, harsh systolic murmur heard over the second left interspace adjacent to the sternum, grade 4 in intensity

(graded from 1 to 6) fading out to grade 2 in intensity in the left subclavicular fossa. There was a marked systolic thrill felt over the base of the heart especially to the left of the sternum. In the fourth and fifth left intercostal spaces adjacent to the sternum a somewhat high pitched, blowing diastolic murmur, grade 2, was heard.

The blood pressure readings were always the same on both arms, varying from 120/68 to 162/82 at different times while under observation with a tendency to increase as she came nearer to term, the highest reading being 170/80 at the time of delivery. The femoral blood pressure varied from 87/78 to 90/78. At times only a few systolic beats could be heard at about 87. As the brachial blood pressure increased during pregnancy there was no parallel increase in the femoral blood pressure. Three days before delivery the brachial blood pressure was 140/80 with the cardiac findings as previously described. One week after delivery her pressure was 152/70, later dropping to 130/70. When seen in the clinic two months after delivery her blood pressure was 120/70 and her physical findings were unchanged. She felt perfectly well at this time and had no complaints.

The lungs were normal with the breath sounds somewhat louder at the right apex and left base. The liver edge could be felt two inches below the xiphoid. The spleen was not enlarged while under observation. The extremities were normal. There was no clubbing or edema. It was noted at the time that her feet seemed small. The reflexes were normal. Laboratory findings were negative.

A diagnosis of coarctation of the aorta was made as a result of the physical examination and this diagnosis was subsequently confirmed by X-ray findings.

The electrocardiogram taken on August 23, 1939, twenty-four days before delivery (Fig. 1) shows the action regular, rate 106. P waves are quite broad and slightly notched. Conduction time is normal. There is slight widening of the QRS. The QRS deflections are high and diphasic in leads 2, 3 and 4. There is a slight tendency toward left axis deviation. The T wave is rather high and pointed in all leads. In general, the tracing is similar to those seen in congenital heart disease. The electrocardiogram taken on October 30, 1939, six weeks and two days after delivery, (Fig. 2) is

almost identical with the previous tracing except for a flattening of T₃. X-ray examination of the chest on August 23, 1939 in the antero-posterior view shows the heart enlarged. (Fig. 3) The aortic knob is not identified. The supracardiac shadow is narrow. The left border is unusually straight with a prominence in the region of the pulmonary conus. There is scalloping of the ribs on both sides from the third to the seventh inclusive. There is increased density of the hilus shadows particularly on the right and in the bronchial tree. The lungs show no active pathology. There is no fluid in the pleural spaces. Findings are typical of coarctation of the arch of the aorta.

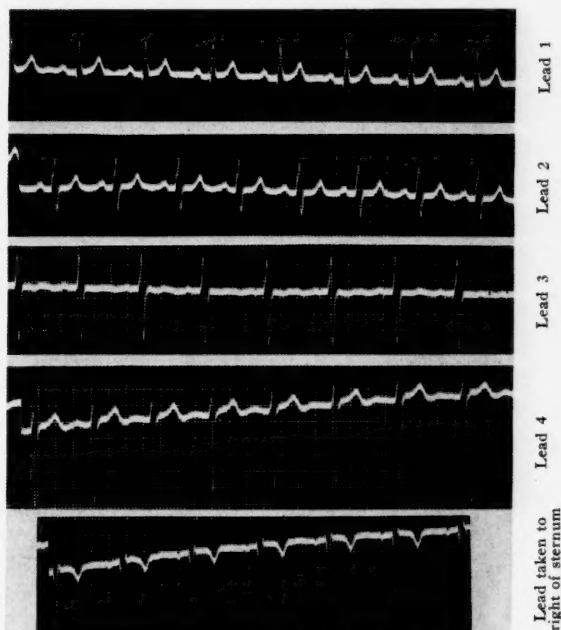


FIGURE 2. Electrocardiogram made six weeks post-partum. Note similarity to Figure 1 except in flattening of T₃. Fifth lead right of sternum.

The patient was admitted to the State Infirmary on March 7, 1940 because of loss of weight and fatigue of about five weeks' duration. She complained of a mild orthopnea but denied all other cardiorespiratory symptoms. Her blood pressure was recorded as 146/60. It was noted that she had

two small petechiae under the lower left eyelid. The liver and spleen were palpable. No tenderness or pulsations were noted.

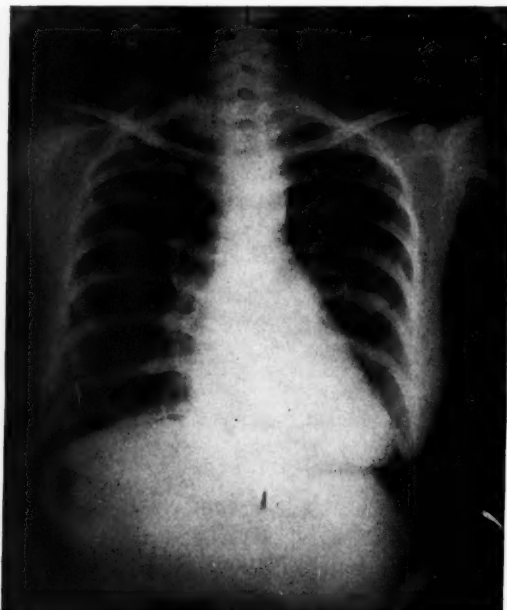


FIGURE 3. Teleoroentgenogram showing enlarged left ventricle, straight left border, prominence in region of pulmonary conus, narrow supracardiac shadow and scalloping of ribs. Twenty-four days before delivery.

A diagnosis of subacute bacterial endocarditis was made and she was treated with sulfapyridine. On March 25, 1940 she suddenly developed dyspnea, cyanosis, orthopnea, and a rapid and feeble pulse and lost consciousness. She regained consciousness after oxygen and stimulants were given. Thirty minutes later she developed the same symptoms and died.

Laboratory findings at the State Infirmiry were as follows: There was a rapid sedimentation rate. Staphylococci were found in the urine on more than one occasion. One blood culture was negative. The white blood count was 10,700, with 77% neutrophils.

X-ray examination made twelve hours after admission revealed a marked enlargement of the heart with extensive mottled density throughout both lungs. There was no fluid in the pleural cavity.

There was no autopsy.

Comment

Coarctation of the aorta associated with pregnancy is probably much less rare than the few reported cases indicate. In order to determine the incidence of death in this condition and to better evaluate the effect of pregnancy on women with coarctation of the aorta, it is necessary that more such cases be reported.

The electrocardiograms in coarctation of the aorta have no characteristic identifying features. If there are associated abnormalities placing appreciable strain on the heart, there may be right or left axis deviation, the type and degree of deviation depending upon the functional disturbances. Since arterial hypertension in the upper part of the body is a characteristic finding, one would expect to find left axis deviation. Cases have been reported with normal axis.

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CHEMOTHERAPY IN INFECTIONS OF THE GENITO-URINARY TRACT

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During the past five or six years the discovery of several chemotherapeutic drugs has changed the entire outlook on the treatment of urinary tract infections. The first of these drugs to appear was mandelic acid, which was discovered after a search for an organic acid which would act in the urine like beta-oxybutyric acid. It has been previously observed in patients suffering from acidosis that beta-oxybutyric acid was a bactericidal agent.

Read before the Providence Medical Association, February 3, 1941.

Mandelic acid in sufficient concentration in a urine of sufficient acidity will kill all organisms except the streptococcus faecalis and the gonococcus. Calcium mandelic in doses of 8 to 14 grams daily and enough ammonium chlorid to make the p.H of the urine 5.2 or below is the method of administration. We have all had many failures with mandelic acid but the failures were due to lack of concentration of the mandelic acid or that the acidity was not great enough. Damaged kidneys excrete mandelic acid poorly. In many cases it is not possible to acidify the urine without nauseating doses of urinary acidifiers.

Mandelic acid has but few toxic effects other than occasional nausea and the malaise of a chemical acidosis. This drug is still valuable even though it was soon overshadowed by sulfanilamide.

Sulfanilamide has the advantage that it will act in an alkaline as well as an acid urine. Even damaged kidneys are capable of excreting sulfanilamide in concentrations that are bactericidal. In doses of 6.0 grams daily for two or three days and then reducing the dose to 4.0 grams daily or even less sulfanilamide should kill all organisms in the urinary tract including the gonococcus but not the streptococcus faecalis. A survey of the literature shows that 70% of the cases of gonorrhea are cured by sulfanilamide. The high initial dosage is used to kill off most of the organisms at the outset so as to discourage the development of drug resisting strains of the organisms.

Sulfanilamide, however, is a very toxic drug capable of doing severe damage to the tissues of the host. Fever, cyanosis, skin rashes, anemia, leucopenia, nausea, vomiting and liver damage make this drug a dangerous one to use.

Prentiss and Flocks reporting on one hundred and eleven cases that had been receiving sulfanilamide in doses of 6.0 grams daily for 2 days then 4.0 grams thereafter found evidence of liver damage in 49.5%. In this 49.5% the van-den-Bergh readings were above 1 and of these 63% were direct readings indicating true hepatic damage. They also report that jaundice both early and late was one of their commoner complications and they think that patients with definite liver damage should not receive sulfanilamide. Prentiss and Flocks even go so far as to suggest that patients given sulfanilamide today may have hepatic cirrhosis tomorrow.

Sulfapyridine was introduced a few months after sulfanilamide. It originally was intended to be used against the pneumococcus about which Dr. Cutts will tell you, but it was not long before it too was found to have killing powers for bacteria in urine. It is even more efficacious against the gonococcus than sulfanilamide. A survey of the literature shows it to be successful in 84% of the cases. It, like mandelic acid and sulfanilamide has no antiseptic properties against the streptococcus faecalis. Effective doses of sulfapyridine are 1 gram every 6 hours for 3 or 4 days and then 0.32 grams every 8 hours for 2 days or more. Sulfapyridine has its toxic symptoms also which are like those of sulfanilamide only they are less common and not so severe. Sulfapyridine acts against the gonococcus in the tissues and not by way of the urinary flow. Reed Nesbit treated a case of gonorrhea with it with striking results in a patient who had previously had bilateral ureterosigmoidostomies done for intractable cystitis and no urine whatever passed through his bladder and urethra.

Sulfapyridine is excreted in the urine in the acetylated form which precipitates as sheaf like crystals which will form urinary calculi. We have observed and treated one case of bilateral calculus anuria in a man 48 who had received a total dosage of 19 grams in 4 days for pneumonia. At cystoscopy grayish white calculi were seen to be plugging each ureter orifice. The patient had excreted no urine whatever in the previous 12 hours. Fortunately the stones were of the consistency of soft putty and it was not difficult to burrow through them with ureter catheters which were passed to the kidneys and left in place. The catheters were irrigated with warm water which is a good solvent for acetylated sulfapyridine crystals. The catheters were withdrawn at the end of 36 hours and there was no further difficulty in urinary tract.

In 1939 Sulfathiazole was reported by Fosbinder and Water. It has been found to be effective against all organisms found in the urinary tract. Its effectiveness for these organisms on an ascending scale is as follows: *Pseudomonas aeruginosa*, streptococcus faecalis, *Escherichia coli*, *aerobacter aerogenes*, *Proteus ammoniae* and *staphylococcus aureus*. It will be noted that sulfathiazole is the one drug that will kill the streptococcus faecalis but curiously only when the p.H of the urine is low (5.2). Against all other organisms it is more effective at high hydrogen ion concentrations.

Against the gonococcus sulfathiazole is the most effective drug known today. In 100 cases reported by Burkholder and Bang there were 92% cured. Their patients were given an initial dose of 4 grams and then 1 gram every 4 hours for 14 days. The average blood concentration with this dosage was 6.0 mgms %. It is quite likely that this dosage is too high. If 2 or 3 grams daily will not sterilize the urine larger dose will probably not either.

Sulfathiazole is also toxic but to a far less degree than sulfanilamide and sulfapyridine. There were 13 reactions among the 100 cases reported by Burkholder and Bang. 6 had a rash, 5 had mixed bulbar conjunctivitis, 1 had urticaria with painful swollen joints which subsided completely within 24 hours on withdrawal of the drug, 1 had nausea, 5 had fever, and 1 had transitory leucopenia of 2,700 white blood cells. There were no anemias and no other complications.

Sulfathiazole, like sulfapyridine is excreted in the acetylated form which form crystals in the urine. The crystals are small and are often found in the tubules of the kidney which they have been known to plug so completely that death from uremia has followed. It is absolutely necessary when giving sulfathiazole to see to it that the daily urinary output is at least 1500 cc's. Patients should be watched daily preferably in the hospital and frequent blood counts and blood sulfathiazole determinations should be done.

Summary

We have tried to crowd into a ten minute paper the present status of chemotherapy in urinary infections. It would seem that sulfathiazole is in every way superior to the others. At a concentration of 200 mgms per 100 cc of urine it will cure practically all infections in the urinary tract in which there is no underlying mechanical difficulty such as a foreign body, residual urine or a hydro-nephrosis.

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EMMA PENDLETON BRADLEY HOME

The Emma Pendleton Bradley Home in East Providence celebrates the tenth anniversary of its opening on April 8th, at which time a hospital unique in medical annals completes its first decade of service to the children of Rhode Island.

The Bradley Home came into existence through an endowment left to establish an institution devoted to the study and care of children suffering from nervous disorders. It is the good fortune of the medical profession of Rhode Island that the donors of this endowment wished the Bradley Home to be erected within this state, and that far-seeing trustees, among them our colleagues, Dr. Charles V. Chapin and Dr. Arthur H. Ruggles, have seen to it that the Bradley Home was established as a *hospital*, operating under medical direction and accepting as patients only children referred directly by practicing physicians. In order not to duplicate facilities already available in Rhode Island the Bradley Home has never accepted children for custodial care alone, or provided for the

training of mentally deficient children. However, over a ten-year period approximately 600 boys and girls of good intelligence but presenting severe personality and behavior problems and neurological conditions, such as convulsive disorders and cerebral birth palsies, have been admitted. Many of these children have been treated for long periods of time. Although often patients have been referred to the Bradley Home as a measure of last resort, when medical and community facilities elsewhere have failed, a gratifying response to treatment has been noted in the majority, many of whom have gone on to healthy and useful lives in the community.

It is significant that during the depression years, as a result of a policy allowing Rhode Island children to be treated at greatly reduced rates, over 30 per cent of the patients have been treated entirely without cost to their families, and over 80 per cent have been cared for at rates representing less than a third of the cost of their care. It is to be hoped that so significant a service to underprivileged children may be continued.

The staff of the Emma Pendleton Bradley Home has been, of course, primarily concerned with the care of children referred to the hospital for treatment. However, professional training of physicians and nurses, and an active program of scientific research at the hospital have attracted interest beyond the bounds of Rhode Island. More than 50 physicians from widely scattered localities in the United States and Canada have received training while serving on the house staff during the past ten years. A dozen nurses have completed postgraduate study at the home. Nearly sixty publications of a scientific nature have already emanated from studies carried on in the wards and laboratories of this one small hospital. Particularly noteworthy among these are those connected with electroencephalography, with the drug treatment of children's neuropsychiatric disorders, and with studies on schizophrenia in childhood.

The guiding genius of Dr. Ruggles, who has served as trustee and as superintendent of the hospital since its opening in 1931, must be given much of the credit for the present pre-eminent position of the Emma Pendleton Bradley Home in the medical world. It is to be hoped that the fine work which he and his colleagues have so successfully organized and stimulated will continue for many more decades in the future.

IN 1889 THE AMERICAN MEDICAL ASSOCIATION MET IN NEWPORT

The Fortieth Annual Meeting of the American Medical Association was held at Newport, Rhode Island, June 25 to 28, 1889. The general meeting convened at Music Hall; meetings of the ten sections were held in near-by halls and churches.

In his Address of Welcome, Henry E. Turner gave a running account of the medical history of Newport, of Dr. John Clarke, founder of the first settlement, of Dr. William Hunter and his lectures on Anatomy, of Dr. Isaac Senter and of Dr. George Berkeley. Senator William P. Sheffield gave an Address with the title:—"John Clarke, Physician, Philanthropist, Preacher and Patriot." The Address on Medicine was given by Frederick C. Shattuck; the Address on Surgery by Phineas S. Connor; the Address on State Medicine by William H. Welch; the Address on Ophthalmology by George E. Frothingham.

Sir James Grant of Ottawa, Canada, read an Address on "The Progress of Medical Science during the past Half Century." P. S. Abraham of London spoke on "The Etiology of Leprosy." George Apostoli of Paris contributed a paper on "The Treatment of Salpingo-ovaritis by Electricity."

J. H. Musser spoke on "The Clinical Aspects of Vomiting"; Francis Delafield on "Chronic Endocarditis"; James Tyson on "Premature Labor in Bright's Disease"; Solomon Solis-Cohen on "Food in the Treatment of Consumption"; Maurice Richardson on "Surgery of the Peripheral Nerves"; Arthur T. Cabot on "Operations for Stone in the Bladder"; Robert T. Morris on "What Dressing should be next to the Wound"; J. C. Warren on "Management and Treatment of Large Herniae"; Henry O. Marcy on "The Cure of Hernia by the Use of the Buried Animal Suture"; Charles V. Chapin on "The Purification of Drinking Water for Cities."

William Pepper delivered an Address on "The Life and Labors of Benjamin Rush." Horatio R. Storer, in a paper on "The Medals of Benjamin Rush," found that Rush was the first to suggest employment of anesthesia in obstetrics.

John B. Deaver served as Secretary of the Section on Surgery and with Herman Knapp, W. H. Pancoast, William Brodie, William Osler, and other men of international reputation too numerous for mention here, read and discussed papers.

An extensive entertainment program was provided by the local Committee on Arrangements but the scientific program was of such interest that these attractions were, for lack of time, conspicuously neglected. Apologetically the Editor of *The Journal* of the American Medical Association stated "Nothing but an enthusiastic interest in the real work of the Association could have prevented its members from giving themselves over to a continued round of most attractive entertainments at the City of Newport—A day never to be forgotten was that when—after the Association-work was over—the Rhode Island Medical Society treated its guests to an old-fashioned "clam-bake" on the shores of Narragansett Bay."

THE MEDICAL HOME GUARD

In the event of a national emergency, in which the armed forces of the United States are mobilized, a large number of medical men, now in civil life, will be commissioned as officers and will serve as such; but the entire profession will be called into service. In a country at war the entire population becomes involved. In the case of the medical profession the job is not only to protect the health of the people involved in the essential industries at home on which those fighting forces depend, but also to continue, as always, to furnish the best possible care to the civilian population. At the present time the American Medical Association has on file data regarding every doctor in the United States, which are at the service of the government. Mobilization will mean mobilization of the entire profession. Those whose training and condition make them suitable for duty with troops will be so placed as far as they are needed. The others who remain in civil life will be expected to do their no less important duty as a part of the patriotic response of the doctors of the country to the existing need. This will mean extra work, even hardship at times, and a role which, if apparently less heroic than that of their colleagues in active service, is no less essential to successful national defense. In the case of hospitals it will mean that the remaining staff physicians must accept double or even continuous duty. It will also mean that in hospital practice the places temporarily made vacant by the men in service must

be kept open for them to step into on their return to civil life, and that in private practice their patients must be conscientiously cared for by their colleagues in their absence and eventually returned to them. The practice of collecting fees from such patients and turning over a proportion of these fees to the families of the physicians in service should be conscientiously carried out.

Modern warfare or "total war", as it has been called, now is directed against entire populations. At the present time a London hospital orderly faces more danger than a British infantryman, and his work is of equal importance to his country. When the medical profession of this country is mobilized, every doctor will be involved, and in the city, in the country or with the armed forces each will have ample opportunity to do his full share.

RHODE ISLAND MEDICAL SOCIETY

Treasurer's Report of the Budget

INCOME FOR 1941

Annual Dues	\$4,600.00
Interest from Harris Fund.....	256.40
Interest from Morgan Fund.....	30.10
Providence Medical Association, Use of Building	450.00
Office, Executive Secretary	300.00
Use of Building	50.00
Exhibitors, Annual Meeting, Less Expenses	550.00
	<hr/>
	\$6,236.50
Balance in Bank January 1, 1941.....	2,352.39
	<hr/>
	\$8,588.89

E. M. HARRIS FUND

26 shares Nicholson File Co.....	\$49.40
General Public Utilities Co.....	156.00
A-NY & B-NY Realizing Corp.....	51.00
	<hr/>
	\$256.40

JAMES R. MORGAN FUND

34 shares Providence Gas Company.....	\$30.10
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EXHIBITS — ANNUAL MEETING

Total Receipts from Exhibitors.....	\$710.00
Expenses	149.47
	<hr/>
Net Profit to Rhode Island Medical Society	\$560.53

BUDGET — 1941

Collations and Annual Dinner.....	\$700.00
Expenses of Secretary, Secretary service	100.00
Printing and Postage	225.00
Fuel	600.00
Gas	50.00
Electricity	100.00
Telephone	125.00
City Water	25.00
House supplies and expenses	300.00
House repairs	300.00
Janitor	840.00
Safe Deposit	7.00
Treasurer's Bond	25.00
Librarian	1,660.00
Delegate to American Medical Association	100.00
Medical Library Association Dues.....	15.00
Radio Talks, mimeographing and distributing	50.00
R. I. Medical Journal, donation according to membership	245.00
Expenses of Committees	75.00
Assistant in Library	1,040.00
	<hr/>
	\$6,582.00

Correction

Minutes of the Meeting of the Council, January 16, 1941. R. I. M. J., March, 1941, p. 51.

Dr. Mark Rittner of Providence is a member in good standing of the Rhode Island Medical Society.

NEWPORT COUNTY MEDICAL SOCIETY**Minutes of the Meeting Held February 25, 1941**

The regular meeting of the Newport County Medical Society was held on Tuesday, February 25, 1941 at the Newport Hospital at 8:45 P. M. Dr. Samuel Adelson presided. Minutes of the previous meeting were dispensed with. Dr. Norman MacLeod, chairman of the local committee for the Rhode Island state meeting in Newport in May, rendered remarks on the progress being made for the coming meeting. There was no new business.

The chairman called on Dr. Callahan to introduce the speaker of the evening, Dr. Ernest Daland, Surgeon in Chief of Pondville Hospital and Associate Surgeon at the Massachusetts General Hospital. The subject was, "Cancer of the Gastrointestinal Tract." The speaker prefaced his medical talk with a history of the origin of the state-maintained hospital at Pondville for the treatment and

care of cancer patients. This is part of the statewide educational program for cancer cases in Massachusetts.

1. Cancer of the Esophagus.

At one time nothing could be done for these patients. Now they can be successfully operated upon with the aid of the thoracic surgery. The diagnosis of these cases is usually made conclusively by X-ray although the esophagoscope and biopsy are of great assistance.

Radiation with radium is ineffective because most of the growth is outside the tube. X-ray therapy is better but there is great chance of perforation. It should be used only in small quantities over a period of thirty days. The operation of choice is an abdominal approach for an anastomosis followed by a thoracic operation to remove the esophagus.

2. Cancer of the Stomach.

This condition is more prevalent than at once thought. It is imperative to do a G.I. series early as early diagnosis is of utmost importance. Most patients with vague abdominal symptoms should always have an X-ray study as many suspected cases of ulcers are really cancer. A patient with the usual signs of ulcers of the stomach or duodenum that do not respond to a six-weeks sippy diet regime very frequently have cancer.

Analysis of the stomach contents is often misleading as many cancer patients may have an increased amount of acid. A good many of these ulcers may become cancerous. One of the greatest aids in diagnosis of cancer of the stomach is the gastroscope but this requires a special technique in its use.

Treatment:

X-ray and radium are useless. Surgery is always indicated. Actual visualization is really the only way to tell if the cancer is operable or not. One out of four has liver metastases but most cases are hopeless only because of extensive glandular involvements.

Types of Operations:

A total gastrectomy is a four hour operation, always risky, but is being done with some good results. Sub-total gastrectomy is a better risk and gives about 20% cure. Unfortunately prognosis of cancer of the stomach is still poor with any operation. In obstruction of the lower end of the stomach

due to cancer, a gastro-enterostomy is not of much help. It is better to do a trans-section of the stomach and then join with the jejunum.

3. *Cancer of the Colon.*

The lower the lesion in the colon the more malignant is the growth, so that those cancers of the right side of the colon are usually less malignant than those of the left side of the colon or rectum. Cancer of the right colon or cecum usually calls for the choice of two types of operations. The first is a two-step operation: (a) A short circuit of the terminal ileum. (b) Removal of the right colon. This is better than the next operation which is a Mikulicz operation which involves long drainage.

In cancer of the left colon there are two operations. Cecostomy and after five days followed by a resection of the tumor and colon and then an anastomosis. This is the preferred operation to a Mikulicz. Results are satisfactory.

In cancer of the rectum and sigmoid there are three operations. First: A colostomy which is used on inoperable types or poor risks. Second: For a low lesion patient a colostomy followed by a posterior excision from below. Third: A complete abdominal perineal resection which is best of all and done in the one or two operation.

Conclusion:

In conclusion the speaker stressed the fact that a good preoperative preparation is of great importance in all cancer operations for best results.

Following the talk a very interesting discussion followed which was then followed by a rising vote of thanks to the speaker. There were numerous Army and Navy Medical officers present.

The meeting adjourned at 10:55 P. M. and was followed by collation.

Respectfully submitted,

ALFRED M. TARTAGLINO, M.D.,
Secretary.

PROVIDENCE MEDICAL ASSOCIATION

February Meeting

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, February 3, 1941. The meeting was called to order by President Murray S. Danforth at 8:30 P. M. The Secretary read the minutes of the pre-

ceding meeting which were approved. The Secretary reported that the Executive Committee had authorized the Executive Secretary to be the legislative agent of the Association before the General Assembly during 1941.

The President announced the appointment of Drs. John M. Peters and Dennett L. Richardson to serve as a committee to prepare the obituary of the late Dr. Charles V. Chapin.

Dr. Harry C. Messinger read a resolution endorsing the educational campaign of the American Social Hygiene Association. This resolution was approved by the Association.

WHEREAS, the American Social Hygiene Association, Inc. has seen fit to declare Wednesday, February 5, 1941, as National Social Hygiene Day for the purpose of focussing the attention of the general public on the importance of guarding against venereal disease, and

WHEREAS, the Providence Medical Association has always been willing to lend its support to any campaign directed towards the elimination of disease from this community,

THEREFORE, this Association in meeting assembled this third day of February 1941 does hereby fully endorse and support the educational campaign and the national observance of Social Hygiene day sponsored by the American Social Hygiene Association Inc.

The President announced that any new members who had not signed the Constitution should do so immediately after the meeting. The Secretary reported that the Executive Committee had recommended for election to active membership Dr. Joseph C. McWilliams. Dr. Jesse Mowry moved the acceptance of this candidate and the motion was passed.

The President announced the scientific program on the subject of "Chemotherapy" and introduced Dr. Howard K. Turner who spoke on "Chemotherapy in Infections of the Genito-Urinary Tract." Dr. Turner pointed out the great advances in this field with the advent of the sulfanilamide compounds and emphasized the effectiveness of sulfathiazole against a great many infecting organisms in the urinary tract. Dr. Morgan Cutts spoke on "Chemotherapy in Pulmonary Infections" and outlined the use of sulfapyridine and sulfathiazole and emphasized early vigorous treatment and careful at-

tention to the maintenance of adequate urinary output. Dr. Kalei K. Gregory spoke on "Chemotherapy in Meningococcal Infections" pointing out the great value of early adequate administration of sulfanilamide. Dr. Champ Lyons, Resident Surgeon at the Massachusetts General Hospital, spoke on "Chemotherapy in Osteomyelitis and Compound Fractures", and discussed a great deal of his experimental work in this field. Among other things he advised against the primary closure of potentially infected wounds and pointed out that sulfathiazole alone was frequently ineffective in staphylococcal bacteremia, if unaccompanied by adequate surgical drainage.

The papers were discussed by Drs. Herbert E. Harris, Reginald A. Allen, Vincent Oddo, William Horan, and by Russell Bowman.

The meeting adjourned at 10:25 P. M. Collation was served. Attendance: 145.

Respectfully submitted,

FRANK B. CUTTS, M.D.,
Secretary.

RHODE ISLAND MEDICAL JOURNAL

Report of the Managing Editor for 1940

On January 1, 1939, the Rhode Island Medical Journal had cash on hand, \$362.64, unpaid bills, \$775.36, showing a deficit of \$412.72. On January 1, 1940, there was a balance of \$502.87, with all bills paid. On January 1, 1941, there was a balance of \$1,143.62, with all bills paid. Following is a statement for the year 1940, with a comparative statement for 1939.

January 1, 1939, Cash on hand	\$362.64
Receipts from subscriptions and advertising	3,957.38
	<hr/> \$4,320.02
Expenditures	
Printing and mailing	\$2,473.83
Engraving	37.55
Postage	20.00
Address plates	10.41
Back bills paid	775.36
Managing Editor	500.00
	<hr/> \$3,817.15
January 1, 1940, Cash on hand	502.87
	<hr/> \$4,320.02

January 1, 1940, Cash on hand	\$502.87
Receipts from subscriptions and advertising	4,559.98
	<hr/> \$5,062.85
Expenditures	
Printing and mailing	\$2,842.24
Engraving	118.02
Postage	31.08
Address plates	7.27
Stationery	7.00
Managing Editor	500.00
Advertising solicitor for Convention Number	413.62
	<hr/> \$3,919.23
January 1, 1941, Cash on hand	1,143.62
	<hr/> \$5,062.85

In 1940 the number of pages, the proportion of reading pages and the number of cuts were increased. Average distribution for 1940, 931 copies. Cost per page in 1939, \$6.64, in 1940, \$8.16.

	Reading Matter	Advertising	Total
Pages of 1938	192	214	406
1939	206	252	458
1940	226	254	480

The Rhode Island Medical Society has contributed to the support of the Journal as follows:—\$400.00 to \$450.00 each year from 1917 to 1927, nothing in 1928, \$430.00 each year in 1929-1930, nothing from 1931 to 1938, \$243.00 each year in 1939-1940.

Respectfully submitted,

ALBERT H. MILLER, M.D.,
Managing Editor.

CLINICAL PATHOLOGICAL CONFERENCE

RHODE ISLAND HOSPITAL

Tuesday, April 9, 1940

Case presented by Dr. Morgan Cutts

A 69 year old Irish female patient admitted to the Rhode Island Hospital, January 4, 1939, discharged January 8, 1939.

Present Illness: Three months ago she had a fall but walked home after it without difficulty. It seems likely that this is merely a date that the patient remembers rather than having anything to do with her illness. However, soon after this, she noticed a mass in the right lower quadrant, not painful,

which would sometimes seem soft and sometimes hard and gradually increased in size. A doctor who saw her at this time confirmed the finding of the mass and also told her that she had a weak heart.

Five weeks ago she went to bed because of increasing loss of weight and weakness. She had very little appetite and bowels were irregular. She said that had been so for some years before.

Family and Past History: Essentially non-contributory. No previous cardio-respiratory nor genito-urinary symptoms. No abdominal pain, nausea nor vomiting. No vaginal bleeding since menopause, many years before.

Physical Examination: T. 100. This went down to normal after the first day and rose to 100 the day of her death. P. 120. Pulse totally irregular. There was pulse deficit between elbow and wrist. R. 18, B. P. 110/30. Emaciated—lying flat in bed without discomfort. Pallor or mucous membranes. Heart enlarged to the left in the region of left ventricle both by X-ray and percussion. Large mass in right lower quadrant, firm, non-tender, fixed. It was not fixed to the overlying skin. It was apparently definitely not the liver or not attached to the liver. The upper border could be felt at about the level of the umbilicus. The lower border could be felt extending below the pelvic brim and likewise the left lower border. Abdominal mass felt by rectal examination, extending down into the pelvis where it could be palpated through the abdominal wall.

Blood: Hgb. 30%, R.B.C. 1.76 m, W.B.C. 21,500.

Urine: Negative, two specimens.

Wassermann: Negative.

Electrocardiogram: Auricular fibrillation, digitalis effect.

X-ray: Negative except for a slight enlargement of the heart.

Blood Chemistry: Total protein 4.3, Urea N. 9, Glucose 97.

Note: Surgical and Gyn. consultants felt that the mass was probably a malignant cystadenoma of right ovary and inoperable. Patient became progressively weaker and died quietly on her fifth hospital day.

Discussion

Dr. Morgan Cutts:—There was acute terminal event but she went out slowly and surely. The diagnosis at that time and the feeling on the part of everyone who saw her was that she had a malignancy,

probably arising from the pelvic organs, most likely from the right ovary, to explain this mass in the right lower quadrant. Everyone also agreed that she had arteriosclerotic heart disease and auricular fibrillation. The obvious explanation for the edema seemed to be the low serum protein. There is really very little other data to bring out. I think no one will question very much that she had auricular fibrillation and she did have arterio-sclerosis. Of course you can speculate whether the auricular fibrillation was due to an accident—at the time she fell but this seems to be too far fetched to bring in. I think her edema is probably explained on the basis of her low serum protein. Her hands also showed the edema.

In regard to the mass in the right lower quadrant, I think, with the evidence given, the explanation offered is the most reasonable one to expect. It was evident there was a great loss of weight which suggests malignancy. She was in the right age group. The story that it was sometimes soft and sometimes hard suggests some sort of cystic tumor with possible bleeding at intervals and reabsorption of fluid to change the consistency. Of course there are any number of possibilities that would give you a mass in the right lower quadrant.

One peculiar thing seems to be the white count. It seems a little unusual to have a pelvic malignant tumor with a white count of 21,000. Although there is no history to bear this out it is entirely possible that she has a large inflammatory mass in the pelvis and perhaps the commonest cause would be a ruptured appendix with an appendiceal abscess. That would be my second possibility. I think it would be rare to have a myoma of the uterus or a tumor involving the uterus situated in this position without advertising itself for a long time.

My guess would be—First, Malignant cystadenoma of the ovaries and arteriosclerotic heart disease; second, inflammatory mass in the right lower quadrant, probably due to a ruptured appendix.

Dr. Clarence Bird:—I am struck by the fact that this patient had considerable anemia to explain. That is frequently due to carcinoma of the cecum and I would rather favor that diagnosis in a guess of this type. A degenerating tumor of the fundus of the uterus occasionally causes a certain amount of anemia. Ordinarily there is bleeding from the uterus, there was not in this case. Were there any stools examined for blood?

A.: There is no record of it.

Dr. Bird: — This patient noticed that the tumor was sometimes soft and sometimes hard. Sometimes in tumor of the colon the bowel balloons up over it.

As far as the size is concerned this is larger than most tumors of the cecum are found to be. She had lost considerable weight, which might accentuate the size of the mass and it might have perforated and caused an increase in size. I think the matter of no obstruction has nothing to do with it. There is seldom obstruction in carcinoma of the cecum.

Q.: How large was this mass?

A.: It filled the right lower quadrant.

Postmortem Findings

Dr. B. Earl Clarke: — There was a terminal pneumonia and as far as the heart is concerned there was a minimal amount of fibrosis. The interesting findings are in the abdominal cavity. This large mass (demonstrates specimen) was found in the pelvis, it measures 17 cm. in diameter. The colon is stretched about it here and the duodenum is pulled down and adherent to it here and there are numerous loops of small intestine adherent to it elsewhere. Here the ascending colon is open so that we see its mucosa. The tumor is pushing it up in a nodular manner and there is a definite perforation here. Our belief is that it is involved by a growth from without and is not a primary tumor of the colon. The other pieces of gut that are adherent have no tumor involving the mucosa in any of them. This mass is adherent to the liver by a long pedicle. This pedicle proves to be the bile ducts.

Here is the common, hepatic and bile ducts opening into the duodenum. At this point the cystic duct is given off. As you see, the cystic duct is loose in the mass. In other words, the mass represents the gall bladder. An enormous tumor has apparently originated within the gall bladder and distended it.

In the liver there are numerous little nodules — the largest is about 1 cm. and the rest are smaller. These represent metastatic lesions in the liver. Aside from those there are no other metastatic lesions found. The histology of this is a rather papillary type of growth but it is not all papillary. It is definitely malignant. It reminds me of a case presented here by Dr. Beardsley a little over a year ago where the gall bladder was larger than this and it was also found to be in the pelvis. We considered it a benign papillary tumor of the gall bladder.

A very interesting finding was two nodules on the posterior wall of the stomach. The larger one measured 8 m.m. in diameter and the smaller one 6 m.m. in diameter. The histology shows them to be adenocarcinoma. The histology is different from that of the large tumor or the lesions in the liver so that we feel certain this represents a case of multiple malignancy and these are quite unrelated to the gall bladder tumor.

Q.: Was there any inflammatory process around that?

A.: No there was no inflammatory part to it.

Diagnosis: —

1. Primary carcinoma of the gall bladder (Papillary) with metastases to the liver.
2. Adenocarcinoma of the stomach (early).
3. Terminal pneumonia.

OBITUARY

THOMAS J. SMITH, M.D.

Dr. Thomas J. Smith, who for more than fifty years practiced his profession in the Blackstone Valley, died on November 19, 1940, at the home of his son, Russel C. Smith in Cranston, R. I., with whom he had lived since his retirement from active practice eight years ago.

Dr. Smith was born in Adams, Mass., April 18, 1858, the son of Thomas and Bridget Malone Smith. He studied medicine at the College of Physicians and Surgeons in Baltimore, and opened his office in Valley Falls in 1882. In 1922, he moved his office to Pawtucket.

In the early years of his practice he visited his patients on foot and later became well known throughout the Blackstone Valley as the "horseback doctor," especially in Cumberland and Lincoln.

To further his medical education, he made three trips to Europe and was three times appointed a trustee of the Wallum Lake Sanatorium. At one time he was on the staff of the Homeopathic Hospital.

In addition to his professional interests Dr. Smith was active in the political life of his town and served for three years as a member of the Cumberland School Committee; four years as a member of the Democratic State Central Committee and for many years he was chairman of the board of tax assessors in Cumberland.

Dr. Smith was encouraged in his desire to become a physician by the late Governor Lucius F. C. Garvin, who was his sponsor at the College of Physicians and Surgeons in Baltimore. Dr. Smith took a two year course in Baltimore and in the summer, while on vacation, made calls with Dr. Garvin. At the end of two years Dr. Smith took the examination given by three members of the Rhode Island Medical Society and passed. The practice of medicine was not regulated by the State at that time, and the examination by the representatives of the Rhode Island Medical Society not only conferred membership in the Society but was the equivalent of the present State license. Anyone who wished to enter the medical field could do so by hanging out his shingle. A few years later, however, the State regulated the practice of medicine and required all those who had not been practicing ten years or more to take examinations. Those who had been in practice ten years or more were licensed to continue in practice and were afterwards known as "time-limit men."

When Dr. Smith began practice in Valley Falls in 1884, office visits cost the patients fifty cents and house calls one dollar. As his practice increased he went from walking to horse-back and later he used a buggy. At the height of his practice he required three horses a day. In spite of the demands upon his time and strength Dr. Smith remained always a student and those who knew him were well aware of his interest in the progress of medicine. He was among the first in Rhode Island to use anti-toxin for diphtheria.

Dr. Smith did a really prodigious amount of work. His vigorous advocacy of those things in which he believed, and his unrelenting opposition to anything he disliked, made him a picturesque figure in his community. In his passing the profession of medicine and the people whom he served so well and so long have lost one who embodied the best of those qualities which have always characterized the true family physician.

Dr. Smith leaves two sons, Justin E. Smith of Pawtucket and Russel C. Smith of Providence; three daughters, Mrs. W. H. Robertson of New Milford, Conn., Mrs. Elma Marsan and Miss Brenda A. Smith of Providence, a sister, Mrs. H. A. Briggs of Pawtucket. Dr. Smith's wife, the late Mary (Welsh) Smith, died in 1934.

JOHN E. DONLEY, M.D.

CHARLES F. GORMLY, M.D.

THOMAS F. BLACK, M.D.

Dr. Thomas F. Black died April 2, 1940, after a long illness. He was born September 2, 1862, in Scotland, and came to this country at eight years of age. He attended the public schools and graduated from La Salle Academy and the College of Physicians and Surgeons in Baltimore in 1890. He served an internship at Bay View Asylum in Baltimore and started in practice in Providence in 1891.

He served for two years as a member of the City Common Council and during the World War was a member of the Local Draft Board Division No. 6. He was at one time connected on the staff of the Rhode Island Hospital and of St. Joseph's Hospital.

He is survived by his widow, a son and four daughters, three grandchildren, three sisters and one brother. He was beloved and respected by his patients and his friends, who found him loyal, genial and appreciative.

GEORGE S. MATHEWS, M.D.

FRANK E. McEVoy, M.D.

RECENT BOOKS

PLAGUE ON US. By Geddis Smith, pp. 365, Cloth \$3.00. The Commonwealth Fund, New York, 1941.

The title of this book scarcely explains the real content, for the writer indicates in his Foreword that the work is intended to present to the layman facts and theories concerning communicable diseases, culled from the writings and statements of the scientists. But the whole subject of epidemiology is covered in such detail and in such clear and readable writing that the book may well be read in its entirety by every physician as well.

The general plan of the work includes an historical summary of the great epidemics of history, such as The Black Death, the Plague of 1665-6, Yellow Fever, Cholera and the Influenza epidemic of 1918-19. A chapter is devoted to the theories as to the causation, with detailed descriptions of the many and varied opinions. As the book continues, mention is made of the reaction of the individual to epidemic disease, and that of the crowd—the massing of disease. The writer goes into much detail as to the means of defense against epidemics, both as employed in the past, and as at the present time advised. In carrying on this thought, a number of concrete histories of outbreaks of disease are described at length, giving the facts as to the beginning, progress, and the search for and the final discovery of the source of each. This chapter is interesting, as showing the application of the theories of epidemiology to its practise. There are one or two surprising statements, which stimulate thought. In speaking of inoculation against typhoid fever, the words "a sorry practice" are used, at once arousing the

attention. On reading the context it becomes apparent that the thought of the author was that sanitation should be so good that there should be no danger of typhoid, and therefore, ideally, no need for inoculation. Another reference is to the inadequacy of the mask of gauze, covering the mouth and nose, to prevent contagion. Probably most workers have for some time believed that the mask was of a good deal of value. Most refreshing is the up-to-dateness of the book; for example, reference is made to chemotherapy, the five to seven day method of treating syphilis, and Gramicidin which is as yet only in the experimental stage, but which the writer believes may have great potentialities.

All in all this is a work which is worthy of a place upon the library shelves not only of the layman but also of the physician, whether he be an epidemiologist or not.

HERBERT G. PARTRIDGE, M.D.

MEDICAL EDUCATION IN THE UNITED STATES, 1934-1939, Prepared for the Council on Medical Education and Hospitals of the American Medical Association, pp. 259, Boards, American Medical Association, 1940.

This report prepared for the Council on Medical Education and Hospitals of the American Medical Association is based upon questionnaires completed by medical school officials and upon personal investigations of each school made by representatives of the Council. The mass of data thus obtained covers a wide range including the enumeration of courses, methods of instruction and technical studies of administration, organization and utilization of the medical schools' facilities. Detailed consideration is given to a study of the educational program and the use of clinical facilities. There is hardly an aspect of instruction or of student administration, including the ever important financial support, which is not covered by this report. Particular problems such as clinical clerkships in various specialties have been studied. The teaching in each division, such as pediatrics, medicine et cetera, is reviewed and summarized in comment by the Council based largely upon its observations of the works of these departments in the institutions which seem to be obtaining the most satisfactory results.

CLIFTON B. LEECH, M.D.

THE 1940 YEAR BOOK OF PUBLIC HEALTH. Edited by J. C. Geiger, M.D., pp. 560, with 12 illustrations, Cloth, \$3.00. The Year Book Publishers, Inc., 304 South Dearborn Street, Chicago, 1940.

All medical men are familiar with the Practical Medicine Series of Year Books. It is of interest, therefore, to note that this year for the first time a volume is being issued on public health.

Similar in format to the other volumes, an excellent digest is presented of the literature of the past year.

The book is recommended for those who are interested or are in public health work.

FRANCIS H. CHAFEE, M.D.

GRADUATE MEDICAL EDUCATION IN THE UNITED STATES.

Continuation Study for Practicing Physicians. Council on Medical Education and Hospitals of the American Medical Association. pp. 243, The American Medical Association, Chicago, 1940.

This report constitutes a supplement to this report on Medical Education and actually represents a catalog of the facilities for graduate instruction in the various states. Brief comments are made on the development, importance, and operation of graduate study. The number of special examining boards and boards for certification in certain specialties are evidences of the need for extended medical education. This report covers every aspect of the field.

CLIFTON B. LEECH, M.D.

OFFICE UROLOGY: By P. S. Pelouze, M.D., Assistant Professor of Urology, University of Pennsylvania, Consulting Urologist, Delaware County Hospital, Special Consultant to United States Public Health Service; Member of Board of Directors, American Social Hygiene Association and American Neisserian Medical Society. 766 pages with 443 illustrations, 19 in color. Philadelphia and London: W. B. Saunders Company, 1940. Cloth, \$10.00.

Office Urology by P. S. Pelouze is the title of a well written monograph on the practice of urology. Written in Dr. Pelouze's intimate style it gives many practical suggestions as to the conduct of a busy office practice.

The section on bacteriology is particularly enlightening. He describes the newer cultural methods. The discussion of gonorrhoea, upon which Dr. Pelouze is an admitted authority, is well written, convincing and complete. The uncommon and troublesome complications of gonorrhoea are described at length and the treatment is suggested. The newer sulfonamide drug entities are discussed and evaluated. The more recent ones are but sketchily covered. There is a voluminous chapter on cystoscopy with numerous color plates, sketches and diagrams. The mechanism of the commoner uropathies are described by diagrams and sketches and the rarer lesions are fully covered.

The book throughout is profusely illustrated and the subject matter is presented in a clear, concise and readable fashion. It is a book that should be in the library of the general practitioner as well as that of the specialist.

HOWARD K. TURNER, M.D.

THE COMPLEAT PEDIATRICIAN. By Wilburt C. Davison, M.A., D.Sc., M.D. Third Edition, pp. 256 and index, Cloth, \$3.75, Duke University Press, Durham, N. C., 1940.

An encyclopedia of diagnosis and treatment of the diseases of children. For the use of medical students, internes, general practitioners, and pediatricists. The practical value of the book is attested by the rapidity with which the previous editions have been exhausted. In this edition 3,700 new references have been added to the 7,854 references of the second edition, making a total of over 11,000. The in-

corporated comments of the author, who is Professor of Pediatrics at Duke University School of Medicine, add greatly to the value and interest of the work.

SYNOPSIS OF CLINICAL LABORATORY METHODS. By W. E. Bray, B.A., M.D. Second Edition, pp. 408 with 51 text illustrations and 17 color plates, Cloth, \$4.50. The C. V. Mosby Company, St. Louis, 1939.

Although there are many textbooks in the market of clinical laboratory methods, it is the feeling of the reviewer that there is always room for one more inasmuch as none is perfect.

In this work the author attempts to have brief descriptions of the procedures, with unimportant details omitted. As a result, the book has a businesslike air about it and should prove useful not only for one active in laboratory work but also as a reference book for one who only occasionally enters the laboratory.

The illustrations are on the whole excellent with the exception of those depicting the various types of blood cells. It is admitted that good reproduction of blood cells is difficult to begin with, but poor ones might just as well be omitted.

FRANCIS H. CHAFEE, M.D.

THE ROCKEFELLER FOUNDATION, Annual Report, 1939, pp. 507, 49 West 49th Street, New York, 1940.

Once again the annual report well illustrates the success of the Rockefeller Foundation in achieving the purpose stated in its charter "to promote the well-being of mankind throughout the world." In spite of the disorganized international situation the foundation has carried on its work in many countries in the five divisions of the foundation, namely, International Health, Medical Sciences, Natural Sciences, Social Sciences, and the Humanities. Detailed reviews of the activities of these departments are incorporated in the report. It is evident from these that the foundation is very willing to sponsor new projects and to underwrite novel schemes which give promise of fostering in some way man's well-being and culture. It seems that the emphasis at present is more particularly upon the mechanics of intellectual and social improvement rather than upon the fostering of individual accomplishments in scholarship. Local interest is directed at the allotment to Brown University of aid for the continuance of research on "unique stocks of rabbits representing genetic strains built up over some 35 years of research" carried on previously at Harvard University. A grant has also been made to Brown University for the establishment of a microfilm photographic laboratory which will constitute an important adjunct to the new international journal, *Mathematical Reviews*, which has its headquarters at Brown. In respect to world politics there is interest in grants to the Canadian Institute of International Affairs which is an unofficial and non partisan organization for the study of British Commonwealth and international affairs and their relation to Canada.

CLIFTON B. LEECH, M.D.

VENEREAL DISEASE INFORMATION

Unity of purpose—the control of venereal disease—characterizes two recent statements by the medical profession and by Federal and State agencies.

The first statement is the "Resolution on the Venereal Disease Program" adopted by the House of Delegates of the American Medical Association in June 1940. The second is "An Agreement by the War and Navy Departments, the Federal Security Agency, and State Health Departments on Measures for the Control of the Venereal Diseases in Areas Where Armed Forces or National Defense Employees are Concentrated."

"During the World War, venereal disease in the Army caused the loss of almost 7,000,000 days—equal to a full year's absence from duty for 19,000 men", Surgeon General Thomas Parran points out. "Infections among military personnel originate in the civilian communities. Recent experience indicates that the venereal disease rate in a given military command reflects the efficiency of the venereal disease control program in adjacent communities. The same is true for industrial defense concentrations.

"Effectively carried out", Dr. Parran emphasizes, "the 8-point cooperative program will contribute substantially to the physical fitness of men in the armed and industrial defense forces, and should be of far-reaching importance to the future control of venereal disease. But this must be a cooperative program between health officers, military authorities, police agencies, citizens—and private physicians.

"Recent statements and actions of the American Medical Association demonstrate that, as always, the physicians of the United States will rise to the obligations asked of them."

Increasing demands on private physicians occasioned by the national defense program, accents the need for reliable, current and usable information regarding venereal disease.

Venereal Disease Information presents a monthly digest of the important papers on diagnosis, treatment, pathology, laboratory research, and public health from the entire world. In addition, it publishes important special papers and reports by leading scientists. It is designed to keep both the specialist and the general practitioner informed of developments in clinical management and public health control of syphilis, gonorrhea, and the venereal diseases.

This medical journal of venereal disease has been highly recommended by leaders in all fields of public health. In a rapidly developing and changing field of medical science, the physician interested in venereal disease control from the standpoint of differential diagnosis and treatment will find *V. D. I.* an important aid.

Venereal Disease Information is published monthly by the U. S. Public Health Service. Today it ranks as the Government's "best seller", with the highest paid circulation of any Federal publication. All orders should be directed to the SUPERINTENDENT OF DOCUMENTS, GOVERNMENT PRINTING OFFICE, WASHINGTON, D. C. Subscription fee, 50c per year, in check or money order, *not stamps*.